Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Vivis, Inc dba Remed

Respondent Name
Sentry Casualty Co

MFDR Tracking Number
M4-13-2723-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 24, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We were not aware he was under worker's compensation until 5/13/13. Once we were given this information, we called in to get an authorization in which we were told everything would get paid up to the date of 5/13/13."

Amount in Dispute: $2,142.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No written position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 22 – May 13, 2013	Physical Therapy	$2,142.00	$897.72

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notification absent
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

1. Were the services in dispute subject to prior authorization requirement?
2. What is the applicable rule pertaining to fee guidelines?

3. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on July 2, 2013. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.
2. Per 28 Texas Administrative Code §134.600(p)(5)(C) states in pertinent part, "Non-emergency health care requiring preauthorization includes; (5) physical and occupation therapy services, (C)except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following (1) the date of injury…" Therefore, the Division finds the first six visits did not require authorization and will be reimbursed per applicable fee guidelines.
2. 28 Texas Administrative Code §134. 203(c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). The maximum allowable reimbursement (MAR) will be calculated as follows:
    - Procedure code 97032, service date April 22, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.25 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.25225. The practice expense (PE) RVU of 0.3 multiplied by the PE GPCI of 1.017 is 0.3051. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 0.56569 is multiplied by the Division conversion factor of $55.30 for a MAR of $31.28. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $22.85 at 2 units is $45.70.
    - Procedure code 97124, service date April 22, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.35 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.35315. The practice expense (PE) RVU of 0.41 multiplied by the PE GPCI of 1.017 is 0.41697. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 0.77846 is multiplied by the Division conversion factor of $55.30 for a MAR of $43.05. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $31.52.
    - Procedure code 97035, service date April 22, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.21 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.21189. The practice expense (PE) RVU of 0.15 multiplied by the PE GPCI of 1.017 is 0.15255. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 0.37278 is multiplied by the Division conversion factor of $55.30 for a MAR of $20.61. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $16.40.
    - Procedure code 97530, service date April 22, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.44 multiplied by

the geographic practice cost index (GPCI) for work of 1.009 is 0.44396. The practice expense (PE) RVU of 0.58 multiplied by the PE GPCI of 1.017 is 0.58986. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 1.04216 is multiplied by the Division conversion factor of $55.30 for a MAR of $57.63. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $57.63. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $56.00.

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- Procedure code 97010, service date May 7, 2013, has a status indicator of B, which denotes a bundled code. Payments for these services are always bundled into payment for other services to which they are incident. No payment can be recommended.
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3. The total allowable reimbursement for the services in dispute is $897.72. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $897.72. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $897.72.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $897.72 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		September , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.